10607

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH · COUNTY: Carroll MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Maryland COUNTY: Harford
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: sykesville — LENGTH OF STAY (in this place): 48 years	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: unknown
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Springfield State Hospital	STREET ADDRESS (If rural, give location): ✓

3. NAME OF DECEASED (Type or Print): (First) Anna (Middle) E. (Last) Amos

4. DATE OF DEATH: (Month) November (Day) 5. (Year) 1949

5. SEX: female

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single

8. DATE OF BIRTH: ~~unknown~~ about 1875

9. AGE last birthday: 74 yrs. — If under 1 year: Months. Days. If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Isaac Amos

14. MOTHER'S MAIDEN NAME: Eleanot Robeson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If year, give war or dates of service)

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Hospital records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Generalized arteriosclerosis	about	14 years
Antecedent cause(s)			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Mid-thigh amputation of right leg because of dry gangrene July 21, 49	about	4 months
	(c)		

450.1

97

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Schizophrenia, paranoid type over 48 years

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-2-* , 1942, to 11-4 , 1949, that I last saw the deceased alive on 11-4- , 1949, and that death occurred at 2.30 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Irene L. Hitchman, M.D. — ADDRESS: Springfield State Hospital — DATE SIGNED: 11-5-49

23. BURIAL, CREMATION REMOVAL (Specify): BURIAL — DATE: 11-6-49 — NAME OF CEMETERY OR CREMATORY: WOODSIDE — LOCATION (City, town, or county) (State): BRINKLOW Md.

DATE REC'D BY LOCAL REG.: Nov. 6, 1949 — REGISTRAR'S SIGNATURE: A. Harry Weer

24. FUNERAL DIRECTOR: F.C. HIGINBOTHOM, ELLICOTT CITY Md. — ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
NOV 10 1949
BUREAU V. S.

10608

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH · COUNTY: Carroll MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Maryland COUNTY:
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Henryton — LENGTH OF STAY (in this place): 2mos. 26 days	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore 17
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Henryton State Hospital	STREET ADDRESS (If rural, give location): 1113 Penn., Ave.,

3. NAME OF DECEASED (Type or Print)	(First) JAMES	(Middle) WESLEY	(Last) BATES	4. DATE OF DEATH	(Month) Nov.	(Day) 12	(Year) 1945
5. SEX: Male	6. COLOR OR RACE: Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single	8. DATE OF BIRTH: April 2,1903	9. AGE last birthday: 46 yrs.	If under 1 year: Months. Days	If under 24 hrs.: Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country): Durham, N.Carolina	12. CITIZEN OF WHAT COUNTRY?				
13. FATHER'S NAME: Wesley Bates	14. MOTHER'S MAIDEN NAME: Carrie Fuller						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If year, give war or dates of service)	16. SOCIAL SECURITY No.: 216-10-2217	17. INFORMANT AND ADDRESS: Deceased					

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Pulmonary Tuberculosis — June, 1949

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

002

13b

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug. 17, 1949, to Nov. 12, 1949, that I last saw the deceased alive on Nov. 12, 1949, and that death occurred at 3:50 p.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Reuben Hoffman, M.D.		Henryton, Md.	11/12/49

23. BURIAL, CREMATION REMOVAL (Specify): Burial	DATE: 11-18-49	NAME OF CEMETERY OR CREMATORY: Mt. Auburn Cem.	LOCATION (City, town, or county): Baltimore	(State): Md
DATE REC'D BY LOCAL REG.: 11/12/49	REGISTRAR'S SIGNATURE: Albert Savankhurst	24. FUNERAL DIRECTOR: Mrs Katie R Williams	ADDRESS: 322 N Schroeder St.	

Deputy Local

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
NOV 22 1949
BUREAU V. S.

Evidence for change of birthdate and addition of mother's maiden name shown on Film G122 11/25/49 dm. Birth Certificate.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 10074

MARGIN RESERVED FOR BINDING. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

VS. A15

1. PLACE OF DEATH
COUNTY: Carroll — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Henryton — LENGTH OF STAY (in this place): 5 mos. 10 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Henryton State Sana.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY:
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore-23
STREET ADDRESS (If rural, give location): 253 N. Bruce Street

3. NAME OF DECEASED (Type or Print): (First) ADA (Middle) (Last) BAYNOR

4. DATE OF DEATH: (Month) November (Day) 10 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: May 11, 1945

9. AGE last birthday: 4 yrs. — If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: James G. Baynor

14. MOTHER'S MAIDEN NAME: Mary Louise Holly

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT AND ADDRESS: Mrs. Lillie Baynor (Grandmother)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Miliary Tuberculosis — Interval between onset and death: May 15, 1949

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

019.2

22a

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour): m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 18, 1949, to Nov., 10, 1949, that I last saw the deceased alive on Nov., 10, 1949, and that death occurred at 6:50 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Raleen W. Homan, M.D. — ADDRESS: Henryton, Md. — DATE SIGNED: 11-10-49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE: 11-15-49 — NAME OF CEMETERY OR CREMATORY: Mt Calery — LOCATION (City, town, or county) (State): Brooklandville Md

DATE REC'D BY LOCAL REG. 11-10-49 — REGISTRAR'S SIGNATURE: Albert [illegible] Deputy Local

24. FUNERAL DIRECTOR ADDRESS: Elroy O Wilson — 1060 Brantley Ave.

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MARYLAND STATE DEPARTMENT OF HEALTH

10610

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH· COUNTY Carroll MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED· STATE Maryland COUNTY Washington
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Sykesville — LENGTH OF STAY (In this place) since 10/11/48	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Williamsport
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital	STREET ADDRESS (If rural give location) Route #2

3. NAME OF DECEASED (Type or Print) (First) Harry	(Middle) ---	(Last) BOPPE	4. DATE OF DEATH (Month) 11	(Day) 3	(Year) 1949
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married	8. DATE OF BIRTH 2/19/1885	9. AGE last birthday 64 yrs.	If under 1 year Months — Days — If under 24 hrs. Hours — Min. —
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	10b. KIND OF BUSINESS OR INDUSTRY ---	11. BIRTHPLACE (State or foreign country) Washington County, Maryland	12. CITIZEN OF WHAT COUNTRY? United States		
13. FATHER'S NAME John Boppe		14. MOTHER'S MAIDEN NAME Mary Molly Cunningham			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) unknown (If yes, give war or dates of service) unknown	16. SOCIAL SECURITY NO. unknown	17. INFORMANT Records - Springfield State Hospital			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

493 Immediate cause (a) Pneumonia, unspecified — 3 days

109 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) ---

(c) ---

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Schizophrenia, hebephrenic type — 21 years

19a. DATE OF OPERATION ---	19b. MAJOR FINDINGS OF OPERATION ---	20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) ---	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ---	(CITY OR TOWN) --- (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) --- m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR? ---

22. I hereby certify that I attended the deceased from Feb. 7, 1949, to 11-3, 1949, that I last saw the deceased alive on Nov. 3, 1949, and that death occurred at 11 40 p.m., from the causes and on the date stated above.

SIGNATURE Martin Gross, M.D. (Degree or title) Martin Gross, M. D. ADDRESS Sykesville DATE SIGNED 11/4/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF 11-8-49	NAME OF CEMETERY OR CREMATORY Riverview	LOCATION (City, town, or county) (State) Williamsport Md
DATE REC'D BY LOCAL REG. Nov. 5, 1949	REGISTRAR'S SIGNATURE C. Harry Weer	24. FUNERAL DIRECTOR Edith V Seaf	ADDRESS Williamsport Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1949
U. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10611

CERTIFICATE OF DEATH

Reg. Dist. No. 74

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Carroll — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Sykesville — LENGTH OF STAY (in this place): since 3/4/10
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Wash.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Hagerstown
STREET ADDRESS (If rural give location): ---

3. NAME OF DECEASED (Type or Print): (First) William (Middle) --- (Last) BOVEY

4. DATE OF DEATH: (Month) Nov. (Day) 19 (Year) 19 49

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single

8. DATE OF BIRTH: 1871

9. AGE last birthday: 78 yrs. — If under 1 year: Months —, Days —; If under 24 hrs.: Hours —, Min. —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): huckstering

10b. KIND OF BUSINESS OR INDUSTRY: Huckster

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? United States

13. FATHER'S NAME: Gheodore Bovey

14. MOTHER'S MAIDEN NAME: Maria Miller

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): unkn. (If yes, give war or dates of service): unknown

16. SOCIAL SECURITY NO.: unknown

17. INFORMANT: Records - Springfield State Hospital

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Chronic myocarditis and myocardial degeneration	16 yrs.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Chronic valvular disease with hypertension	16 yrs.
443 92d	(c) ---	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Schizophrenia, catatonic type — 39 yrs.

19a. DATE OF OPERATION: ---

19b. MAJOR FINDINGS OF OPERATION: ---

20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): ---

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: --- (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour): --- m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR? ---

22. I hereby certify that I attended the deceased from Sept. 1, 1947, to Nov. 19, 1949, that I last saw the deceased alive on Nov. 19, 1949, and that death occurred at 11:25 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Martin Gross M.D. — ADDRESS: Martin Gross, M. D. Sykesville, Maryland — DATE SIGNED: 11/21/49

23. BURIAL, CREMATION OR REMOVAL (Specify): Burial — DATE THEREOF: Nov. 24 1949 — NAME OF CEMETERY OR CREMATORY: Springfield Hosp. Cemetery — LOCATION (City, town, or county): Sykesville — (State): Md.

DATE REC'D BY LOCAL REG.: Nov. 24, 1949 — REGISTRAR'S SIGNATURE: C. Harry Keen

24. FUNERAL DIRECTOR: C. H. Keen — ADDRESS: Sykesville Md.

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BUREAU U.S.

10612

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH · COUNTY Carroll MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE Maryland COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Henryton — LENGTH OF STAY (in this place) 5 mos. 14 days	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore -2
HOSPITAL OR INSTITUTION OR STREET ADDRESS Henryton, State Hospital	STREET ADDRESS (If rural, give location) 142 Colvin Street

3. NAME OF DECEASED (Type or Print)	(First) Andrew	(Middle)	(Last) Brown	4. DATE OF DEATH	(Month) Nov. (Day) 1, (Year) 1949
5. SEX MALE	6. COLOR OR RACE Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH 7-4-1931	9. AGE last birthday 18 yrs.	If under 1 year Months Days; If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE	10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Issiah Brown			14. MOTHER'S MAIDEN NAME Lena Jenkins		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If year, give war or dates of service)	16. SOCIAL SECURITY NO. - -		17. INFORMANT Deceased		

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

002 Immediate cause (a) Pulmonary Tuberculosis — April, 1949

Antecedent cause(s)

13b Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 18, 1949, to Nov. 1, 1949, that I last saw the deceased alive on Nov. 1, 1949, and that death occurred at 6:A. m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Reuben Hoffman, M.D.		Henryton, Maryland	11-1-49

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE 11/4/49	NAME OF CEMETERY OR CREMATORY Mt. Calvary Cem.	LOCATION (City, town, or county) (State) A. A. County, Md
DATE REC'D BY LOCAL REG. 11-1-49	REGISTRAR'S SIGNATURE Albert R. Swankham Deputy Local	24. FUNERAL DIRECTOR Joseph G. Locks	ADDRESS 1304 N. Central Ave

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
NOV 3 1949
BUREAU T. S.

MARYLAND STATE DEPARTMENT OF HEALTH

10613

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 75

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Carroll; MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Manchester; LENGTH OF STAY (in this place) 67 yrs.; HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Carroll; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Manchester; STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print): (First) Annie (Middle) M. (Last) Burgoon

4. DATE OF DEATH: (Month) Nov. (Day) 30 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow

8. DATE OF BIRTH: Feb. 28, 1888

9. AGE last birthday: 61 yrs. If under 1 year: Months; Days; If under 24 hrs.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House work

10b. KIND OF BUSINESS OR INDUSTRY: Sugar factory

11. BIRTHPLACE (State or foreign country): Carroll Co. Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: William C Keck

14. MOTHER'S MAIDEN NAME: Eliza Hunt

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY No.: 215-07-1616

17. INFORMANT: Mrs. Milton E. Snyder

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cerebral Arterio Sclerosis — Interval Between Onset and Death: 2 yrs

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Hypertensive C-Vascular Disease — 1 2 yrs

443 93d

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 1949, to Nov. 30, 1949 that I last saw the deceased alive on Nov. 27, 1949, and that death occurred at 4:30a m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Dannie C. Porterfield M.D. Hampstead, Md. 12-1-49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF: 12-3-49

NAME OF CEMETERY OR CREMATORY: Lutheran

LOCATION (City, town, or county) (State): Manchester Md.

DATE REC'D BY LOCAL REG.: Dec 2/49

REGISTRAR'S SIGNATURE: Mrs. H. G. S Denner

24. FUNERAL DIRECTOR: Jacob Winks Sons

ADDRESS: Manchester Md.

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DEC 10 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

10614

Reg. Dist. No. 77

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY Carroll; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hampstead (rural); LENGTH OF STAY (in this place) Life; HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Carroll; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hampstead R.D. #1; STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) John (Middle) Arthur (Last) Bush

4. DATE OF DEATH: (Month) 11 (Day) 4 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, ~~DIVORCED~~, (Specify): Married

8. DATE OF BIRTH: 10/20/1874

9. AGE last birthday: 75 yrs. If under 1 year: Months; Days; If under 24 hrs.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Agriculture

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Murray Bush

14. MOTHER'S MAIDEN NAME: Elinora Murray

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If year, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: Edgar M. Bush M.D. Hampstead Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1 Immediate cause (a) Coronary Occlusion — Interval Between Onset and Death: 24 hours

Antecedent cause(s)

94a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: —

19b. MAJOR FINDINGS OF OPERATION: —

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): —

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): —; (CITY OR TOWN): —; (COUNTY): —; (STATE): —

TIME OF INJURY (Month) (Day) (Year) (Hour) m.: —

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from Nov 4, 1949, to Nov 4, 1949 that I last saw the deceased alive on Nov 4, 1949, and that death occurred at 4:30 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Frank E Bush M.D. ADDRESS: Hampstead Md DATE SIGNED: 11-4-49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial; DATE: Nov 7/49; NAME OF CEMETERY OR CREMATORY: Hampstead; LOCATION (City, town, or county) (State): Carroll Co Md

DATE REC'D BY LOCAL REG.: Nov. 6, 1949; REGISTRAR'S SIGNATURE: John S. Hughes

24. FUNERAL DIRECTOR: Edw. C. Tipton ADDRESS: Hampstead Md

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10615

CERTIFICATE OF DEATH

Reg. Dist. No.....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH · COUNTY: Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Sykesville | LENGTH OF STAY (in this place): 3 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Maryland — COUNTY: ----
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore City
STREET ADDRESS (If rural give location): 21 S. Monastery Ave.

3. NAME OF DECEASED (Type or Print): (First) William (Middle) --- (Last) Cooke

4. DATE OF DEATH: (Month) 11 (Day) 15 (Year) 1949

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): sep.

8. DATE OF BIRTH: 4-20-82

9. AGE last birthday: 67 yrs. | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Engineer

10b. KIND OF BUSINESS OR INDUSTRY: ----

11. BIRTHPLACE (State or foreign country): Baltimore, Md

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: James B. Cooke

14. MOTHER'S MAIDEN NAME: Josephine Fenge

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): unknown | (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Records of Springfield State Hospital

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Coronary occlusion	1 hour
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Arteriosclerosis	more than 3 years
260 61	(c) Diabetes	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Psychosis with cerebral arteriosclerosis — 3 years

19a. DATE OF OPERATION: ----

19b. MAJOR FINDINGS OF OPERATION: ----

20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): ----
PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY: ----
(CITY OR TOWN): ---- (COUNTY): ---- (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour): ---- m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?: ----

22. I hereby certify that I attended the deceased from Sept. 1, 1947, to November 15 1949, that I last saw the deceased alive on Nov. 15, 1949, and that death occurred at 8,15 p.m., from the causes and on the date stated above.

SIGNATURE Martin Gross, M.D. (Degree or title) — ADDRESS Sykesville, Md. — DATE SIGNED 11-15-49

Martin Gross M.D.

23. BURIAL, CREMATION REMOVAL (Specify): Burial
DATE THEREOF: 11/18/49
NAME OF CEMETERY OR CREMATORY: London Park Cem.
LOCATION (City, town, or county) (State): 3801 Frederick Ave

DATE REC'D BY LOCAL REG.: Nov. 16, 1949
REGISTRAR'S SIGNATURE: A. W. Nedrich
24. FUNERAL DIRECTOR: John J. Gowan & Son
ADDRESS: 2 Hollins St.

10616

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: CARROLL — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Sykesville
LENGTH OF STAY: 2½ months
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY:
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore
STREET ADDRESS (If rural give location): 1207 W. Fayette Street

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Harry	Edward	Cordy	11	2	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
male	white	separated	1-15-84	65 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
paper hanger	/	Bristol	England

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Aaron Cordy	Mary

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
/	/	Records of Springfield State Hospital

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Acute myocarditis	5 days
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Psychosis with syphilitic meningo-encephalitis	2½ years
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Arrested chronic fibrous lung tuberculosis — more than 1½ yr.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
/	/	Yes X No

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
/	/	/		

TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
/			m.		/

22. I hereby certify that I attended the deceased from 2-9-, 1948, to 11-2, 1949, that I last saw the deceased alive on 11-2, 1949, and that death occurred at 9.03 p.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Martin Ervin, M.D.		Sykesville, Md.	11-2-49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	11/4/49	Meadow Ridge	Dorsey	Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Nov. 3, 1949	C. Henry Ward	Wm. Cook Inc	1217 St. Paul St.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10617

CERTIFICATE OF DEATH

Reg. Dist. No. 181

MARGIN RESERVED FOR BINDING. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

VS. A15

1. PLACE OF DEATH: COUNTY Carroll MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Mt Airy; LENGTH OF STAY (In this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Carroll; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Mt Airy; STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print): (First) John (Middle) William (Last) Crouse

4. DATE OF DEATH: (Month) Nov (Day) 22 (Year) 1949

5. SEX: M

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: 1-27-1879

9. AGE last birthday: 70 yrs. If under 1 year: Months, Days; If under 24 hrs: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): R.R. Trackladen

10b. KIND OF BUSINESS OR INDUSTRY: B&O RR

11. BIRTHPLACE (State or foreign country): Maryland.

12. CITIZEN OF WHAT COUNTRY: U. S.

13. FATHER'S NAME: George E. Crouse

14. MOTHER'S MAIDEN NAME: Sarah Molesworth

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If year, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Lewis Wm Crouse, Mt. Airy. Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

540.1 Immediate cause (a) Generalized Peritonitis — Interval between onset and death: 24 hrs

Antecedent cause(s)

117a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Probable Perforated Gastric Ulcer — 24 hrs

(c) Gastric Ulcers for years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov 21, 1949, to Nov 22 1949, that I last saw the deceased alive on Nov 21, 1949, and that death occurred at 2 50 a m., from the causes and on the date stated above.

SIGNATURE (Degree or title) C. M. VanPoole M.D. ADDRESS Mt Airy md DATE SIGNED 11-22-49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial DATE 11-24-1949 NAME OF CEMETERY OR CREMATORY: Pine Grove LOCATION (City, town, or county) (State): Mt. Airy, Md.

DATE REC'D BY LOCAL REG. Nov 23/49 REGISTRAR'S SIGNATURE: Thos D Snyder

24. FUNERAL DIRECTOR: C M. Waltz ADDRESS: Winfield. Md.

10618

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 78

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH
COUNTY: Carroll — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural--Taylorsville
LENGTH OF STAY (in this place): 14 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS:

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural--Taylorsville
STREET ADDRESS (If rural give location): R.D. Mt. Airy, Md.

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
DOROTHY	L.	CUMMINS	NOV.	21	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year Months	Days	If under 24 hrs. Hours	Min.
female	white	Married	3-16-1904	45 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Maryland	U.S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Dohney Nygren	Lilly Lindsay

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY No.	17. INFORMANT
no	none	Philip L. Cummins, Mt. Airy, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

170 **Immediate cause** (a) Carcinoma of Lung — 7 months

50 **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b) Metastasis from Carcinoma of Breast — 2 years.
(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
April 1947	Mastectomy - Carcinoma of Breast	Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from April 10th, 1949, to Nov. 21st, 1949, that I last saw the deceased alive on Nov. 20th, 1949, and that death occurred at 6 A. m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Luther Bare — ADDRESS: Westminster, Maryland — DATE SIGNED: 11/21/49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town or county) (State)
BURIAL	11-23-1949	Taylorsville	Taylorsville, Carroll Co. Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
11-22-'49	E. M. Farver	C. M. Waltz,	Winfield, Md.

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10619

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Sykesville
LENGTH OF STAY (in this place) 1 yr. 4 mos. 20 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY City
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore
STREET ADDRESS (If rural give location) 103 S. Spring Street

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Clifton		Danner	11	17	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
male	white	single	8-11-27	22 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY Welder
11. BIRTHPLACE (State or foreign country) Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Walter Danner
14. MOTHER'S MAIDEN NAME Anna May Danner

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown
16. SOCIAL SECURITY No.
17. INFORMANT Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

002 **Immediate cause** (a) Pulmonary Tuberculosis — 18 mos.

136 **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) — (c)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Psychosis with Mental Deficiency — 2 yrs.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April 27, 1948, to Nov. 17, 1949, that I last saw the deceased alive on Nov. 17, 1949, and that death occurred at 7:10 A. m., from the causes and on the date stated above.

SIGNATURE Robert W. Taylor (Degree or title) M.D. — ADDRESS Springfield State Hospital, Sykesville, Maryland — DATE SIGNED Nov. 17, 1949

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	11-24-49	Grundy	Grundy, W. Va.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Nov. 20, 1949	C. Harry Weir	C. H. Weir	Sykesville, Md.

VS. A15

Evidence for addition in 18c shown on:

10620

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

FILM No. G 122 NOV 23 1949

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH: COUNTY Carroll MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Carrollton — LENGTH OF STAY (in this place) 1 yr.	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Carrollton
HOSPITAL OR INSTITUTION OR STREET ADDRESS ✓	STREET ADDRESS (If rural give location) ✓

3. NAME OF DECEASED (Type or Print) (First) SARAH (Middle) G (Last) DAVIDSON

4. DATE OF DEATH (Month) Nov (Day) 11 (Year) 1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year Months	Days	If under 24 hrs. Hours	Min.
F	W	W	June 11 - 1860	89 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None	✓	Maryland	U S A

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Benjamin Brown	Susan Isaac

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY No.	17. INFORMANT
✓	✓	Mr Wm B Davidson

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) General breakdown failing circulation — 6 mo.

782.4 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Asthenia — 2 mo.

162 b (c) Anorexia. Myocardial failure (11/22/49 - G.S.) — 1 mo

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct, 1949, to Nov 7, 1949, that I last saw the deceased alive on Nov 7, 1949, and that death occurred at Nov. 11 m., from the causes and on the date stated above.

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
Cyril E Fowble, M.D.	Upperco, Md.	Nov 11-49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	Nov 14/49	Wesley	Carroll Co	Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
11/15/49	[illegible]	Edw C Tipton - Hampstead	Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10621

CERTIFICATE OF DEATH

Reg. Dist. No. 79

1. PLACE OF DEATH · COUNTY: Carroll — MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Maryland — COUNTY: Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Keysville — LENGTH OF STAY (in this place): 30 yrs	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Keymar, Rural
HOSPITAL OR INSTITUTION OR STREET ADDRESS:	STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Harry	W.	Dinterman	Nov.	13	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
M	white	married	Dec. 20, 1897	52 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer		Md	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
William Dinterman	Annie Eyler

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
No	none	Mrs. Daisy Moser Dinterman, Keymar, Md. Rural

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

420.1 **Immediate cause** (a) Coronary artery disease

Antecedent cause(s)

94a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from ——, 19....., to ——, 19....., that I last saw the deceased alive on ——, 19....., and that death occurred at 7:32 a.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS		DATE SIGNED
James T. Mantz	Deputy Medical Examiner	Westminster	Md	11-13-49

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	Nov. 16, 1949	Keysville	Keysville, Md.	

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Nov. 15/1949	Daisy M. Powell	C.O. FUSS & SON	Taneytown, Md.

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NOV 18 1949
BUREAU Y. S.

MARYLAND STATE DEPARTMENT OF HEALTH

10622

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Carroll; MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural: Sykesville; LENGTH OF STAY (in this place) 16 days; HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Washington; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural: Hagerstown; STREET ADDRESS (If rural, give location) Route #2 ✓

3. NAME OF DECEASED (Type or Print): (First) Nettie (Middle) (Last) Dommel

4. DATE OF DEATH: (Month) November (Day) 12 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: 1870

9. AGE last birthday: 79 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unkown

10b. KIND OF BUSINESS OR INDUSTRY: unknown

11. BIRTHPLACE (State or foreign country): unknown

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service): No

16. SOCIAL SECURITY No.: None

17. INFORMANT AND ADDRESS: Hospital records: Sykesville, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
420.0 Immediate cause	(a) Coronary Sclerosis	Indefinite
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 93d	(b) Aspiration pneumonia (bilateral)	13 days
	(c) Arteriosclerotic heart disease	Indefinite

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Senile psychosis with agitation "

19a. DATE OF OPERATION; 19b. MAJOR FINDINGS OF OPERATION; 20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify); PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.); (CITY OR TOWN); (COUNTY); (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.; INJURY OCCURRED While at Work ☐ Not While At work ☐; HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct. 27, 1949, to Nov. 12, 1949, that I last saw the deceased alive on Nov. 12, 1949, and that death occurred at 4:00 P m., from the causes and on the date stated above.

SIGNATURE Henry C. A. Mead, M. D. (Degree or title) ADDRESS Springfield State Hospital P.O. DATE SIGNED 11/13/49

23. BURIAL, CREMATION REMOVAL (Specify): Burial; DATE 11/15/49; NAME OF CEMETERY OR CREMATORY Smithsburg Cemetery; LOCATION (City, town, or county) Smithsburg; (State) Maryland

DATE REC'D BY LOCAL REG. Nov. 13, 1949; REGISTRAR'S SIGNATURE C. Harry Weer; 24. FUNERAL DIRECTOR Fred W. Kaiser, Hagerstown, Md. ADDRESS

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NOV 15 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

10623

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH: COUNTY: CARROLL — MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: WESTMINSTER; LENGTH OF STAY (in this place): 8 YRS.; HOSPITAL OR INSTITUTION OR STREET ADDRESS: 106 E. GREEN ST.	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: MARYLAND; COUNTY: CARROLL; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: WESTMINSTER; STREET ADDRESS (If rural, give location): 106 E. GREEN ST.

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
CARRIE	M.	ELMER	NOV.	29	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months / Days / Hours / Min.
FEMALE	WHITE	MARRIED	FEB. 18, 1879	70 yrs.	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
NONE	NONE	MARYLAND	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
DR. WILLIAM WELSH	NOT KNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
NO	NONE	MRS. W. B. WALTON BETHESDA, MD.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Cardio-Renal-Vascular Disease	about 5 years
Antecedent cause(s)		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Shock from a fall in home	2 days
	(c) Fracture of ribs	2 days

442

1860

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. (b) x (c)

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
none		Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
no				

TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
			m.		

22. I hereby certify that I attended the deceased from 11-1, 1948, to 11-29-49, 19..., that I last saw the deceased alive on 11-29, 1949, and that death occurred at 8 a. m., from the causes and on the date stated above.

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
A. Billingslea, M.D.	Westminster, Md.	11-29-49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Dec. 1, 1949	Druid Ridge Cemetery	Pikesville Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
11/30/49	[signature]	J. Francis Reese	Westminster, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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DEC 5 1949
BUREAU V. S.

10624

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Eldersville
LENGTH OF STAY (in this place) Life
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Md. COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Eldersville
STREET ADDRESS (If rural, give location) Sykesville P.O.

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
William	Morgan	Enos	Nov.	16	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year Months.	Days	If under 24 hrs. Hours	Min.
M	W	Widowed	May 18 1874	75 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farm Hand	Retired	Md.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Hiram Enos	Mary C. Bowie

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
No —	None	Mrs Wm Pullen - Sykesville, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331 **Immediate cause** (a) Cerebral Hemorrhage — Interval Between Onset and Death: 4 days

Antecedent cause(s)

83a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 11/13/49, 19..., to 11/16/..., 1949, that I last saw the deceased alive on 11/16/..., 1949, and that death occurred at 7½ P m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Wm. E. Martin	M.D.	Randallstown	Md 11-17-49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Nov. 19, 1949	Freedom	Eldersburg, Carroll Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS
Nov. 18, 1949	C. Harry Weer	C. H. Weer - Sykesville, Md.

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10625

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH · COUNTY: Carroll MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Maryland COUNTY: A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Henryton — LENGTH OF STAY (in this place): 8 Mos. 28 days	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Parole
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Henryton State Hospital	STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)	(First) FANNIE	(Middle) MAE	(Last) GRAVES	4. DATE OF DEATH	(Month) Nov.	(Day) 13	(Year) 1949
5. SEX: Female	6. COLOR OR RACE: Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single	8. DATE OF BIRTH: Sept. 4, 1931	9. AGE last birthday: 18 yrs.	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Scholar	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): Stanardsville, Va.,	12. CITIZEN OF WHAT COUNTRY?				
13. FATHER'S NAME: Cleveland Graves	14. MOTHER'S MAIDEN NAME: Grace Natter						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If year, give war or dates of service)	16. SOCIAL SECURITY NO.: None	17. INFORMANT AND ADDRESS: Deceased					

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
002 Immediate cause	(a) Pulmonary Tuberculosis	Oct., 1948
Antecedent cause(s)		
13 b Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb. 18, 1949, to Nov. 13, 1949, that I last saw the deceased alive on Nov. 13, 1949, and that death occurred at 10:20p.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Reuben Hoffman, M.D.		HENRYTON, M.D.	11/13/49

23. BURIAL, CREMATION REMOVAL (Specify): Burial	DATE: Nov 17, 1949	NAME OF CEMETERY OR CREMATORY: Brewer Hill Cem	LOCATION (City, town, or county) (State): Annapolis Md.
DATE REC'D BY LOCAL REG.: 11/13/49	REGISTRAR'S SIGNATURE: Albert Swankhans	24. FUNERAL DIRECTOR: William Reese, II - 108 Annapolis, Md.	ADDRESS: Washington St

Deputy Local

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

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M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

I

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10626

CERTIFICATE OF DEATH

Reg. Dist. No. 81

1. PLACE OF DEATH: COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Union Bridge
LENGTH OF STAY (In this place) 13 mos.
HOSPITAL OR INSTITUTION OR STREET ADDRESS W. Broadway

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Union Bridge
STREET ADDRESS (If rural, give location) W. Broadway

3. NAME OF DECEASED (Type or Print) (First) Mary (Middle) A. L. (Last) Warehime Hall

4. DATE OF DEATH (Month) Nov. (Day) 12 (Year) 1949

5. SEX F
6. COLOR OR RACE W
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) widow
8. DATE OF BIRTH April 19-1864
9. AGE last birthday 85 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None
10b. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (State or foreign country) Md.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Samuel Warehime
14. MOTHER'S MAIDEN NAME Mary Morelock

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT AND ADDRESS Foster Warehime

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Congestive Pneumonia

422.2 Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Chronic Myocarditis

93d (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 26, 1949, to Nov 12, 1949, that I last saw the deceased alive on Nov 12, 1949, and that death occurred at 6 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) T. H. Legg MD
ADDRESS Union Bridge
DATE SIGNED 11-13-49

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE Nov. 15-1949
NAME OF CEMETERY OR CREMATORY Pleasant Valley Cemetery
LOCATION (City, town, or county) Pleasant Valley (State) Md.

DATE REC'D BY LOCAL REG. Nov 13, 1949
REGISTRAR'S SIGNATURE Leslie L. Repp
24. FUNERAL DIRECTOR H Bankard Son Westminster
ADDRESS Md.

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BUREAU T. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10627

CERTIFICATE OF DEATH

Reg. Dist. No. 7H

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A5

1. PLACE OF DEATH
COUNTY: Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Eldersburg
LENGTH OF STAY (in this place): 14 months
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Walnut Ave 17

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Md. — COUNTY: Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Eldersburg
STREET ADDRESS (If rural, give location): Walnut Ave 17

3. NAME OF DECEASED (Type or Print): (First) Idella (Middle) Claretta (Last) Hedges

4. DATE OF DEATH: (Month) 11 (Day) 6 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Jan. 8, 1878

9. AGE last birthday: 71 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Maryland, U.S.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Fred Fogle

14. MOTHER'S MAIDEN NAME: Sarah Shoemaker

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If year, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: Mr. Oscar Hedges, Eldersburg.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Pneumonia	3 days
Antecedent cause(s)		
309		
109 b Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Morbus mentalis	9 months
	(c) Decubitus	1 month

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | **19b. MAJOR FINDINGS OF OPERATION** | **20. AUTOPSY?** Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | **PLACE** (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | **INJURY OCCURRED** While at Work ☐ Not While At work ☐ | **HOW DID INJURY OCCUR?**

22. I hereby certify that I attended the deceased from Aug. 20, 1949, to Nov. 6, 1949, that I last saw the deceased alive on Nov. 4, 1949, and that death occurred at 3 55 a.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
J. W. Hunter	M.D.	Sykesville, Md.	11-6-49

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	Nov. 8 1949	Mt. Olivet	Frederick,	Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Nov. 7, 1949	C. Harry Keen	C. H. Keen	Sykesville Md.

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NOV 10 1949
BUREAU V. S.

10628

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 7

1. PLACE OF DEATH: COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural, Westminster
LENGTH OF STAY (in this place) 37 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Union Mills

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural, Westminster
STREET ADDRESS (If rural, give location) Union Mills

3. NAME OF DECEASED (Type or Print) (First) Arthur (Middle) Littleton (Last) Hollinger

4. DATE OF DEATH (Month) Nov. (Day) 16 (Year) 1949

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married
8. DATE OF BIRTH Nov. 29, 1880
9. AGE last birthday 68 yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cabinet Maker & Antique Dealer
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Adams County, Pa.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Noah Hollinger
14. MOTHER'S MAIDEN NAME Margaret Kauffman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No. (If year, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT AND ADDRESS Stewart Hollinger, Westminster, Md. R.D

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
722.0 Immediate cause	(a) Coronary Thrombosis	Sudden
Antecedent cause(s)		
93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Coronary Sclerosis & chronic myocarditis	5 or 6 yrs
	(c) Chronic arthritis	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 1, 1949, to Nov 16, 1949, that I last saw the deceased ~~alive~~ dead on Nov 16, 1949, and that death occurred at 1:00 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
W Glenn Speicher Westminster Md November 16/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE 11/19/49
NAME OF CEMETERY OR CREMATORY St. Marys Union Cemetery.
LOCATION (City, town, or county) (State) Silver Run, Carroll Co, Md.

DATE REC'D BY LOCAL REG. 11/16/49
REGISTRAR'S SIGNATURE [signature]
24. FUNERAL DIRECTOR ADDRESS J. M. Little & Son, Littlestown, Pa.
By R. A. Little

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
NOV 21 1949
BUREAU V. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

M

I

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10629

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH
COUNTY: Carroll — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural - Sykesville
LENGTH OF STAY (in this place): 36 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Lonaconing
STREET ADDRESS (If rural, give location): 17 Allegany Street

3. NAME OF DECEASED (Type or Print): (First) Verna (Middle) Irene (Last) Knippenburg

4. DATE OF DEATH: (Month) November (Day) 12 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: Sept. 11 '97

9. AGE last birthday: 52 yrs. — If under 1 year: Months / Days / Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cooking & clerical

10b. KIND OF BUSINESS OR INDUSTRY: Home & office

11. BIRTHPLACE (State or foreign country): Allegany Co. Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Frederick Knippenburg

14. MOTHER'S MAIDEN NAME: Marie Pritchard

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service): No.

16. SOCIAL SECURITY No.: NONE

17. INFORMANT AND ADDRESS: Hospital records; Sykesville, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
340.3 Immediate cause	(a) Meningitis - etiology unknown	7 weeks
8/a Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Old left hemiplegia - etiology unknown — Indefinite

19a. DATE OF OPERATION: None

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from October 7 1949, to November 12 1949, that I last saw the deceased alive on Nov. 12, 1949, and that death occurred at 10:05 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Henry C. A. Mead, M. D. — ADDRESS Springfield State Hospital, P.O. — DATE SIGNED 11/12/49

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE: Nov. 15-49 — NAME OF CEMETERY OR CREMATORY: Allegany Cemetery — LOCATION (City, town, or county) (State): Frostburg, Md

DATE REC'D BY LOCAL REG.: Nov. 13, 1949 — REGISTRAR'S SIGNATURE: C. Harry Weis

24. FUNERAL DIRECTOR — ADDRESS: M. Eichhorn Lonaconing, Md

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NOV 15 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

10630

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 81

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Mt. Airy | LENGTH OF STAY (In this place) 14 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Mt. Airy
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) JOHN (Middle) LEVI (Last) LARE

4. DATE OF DEATH: (Month) Nov. (Day) 3 (Year) 1949

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) married

8. DATE OF BIRTH: Nov. 20-1870

9. AGE last birthday: 78 yrs. | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer-Retired

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Charles H. Lare

14. MOTHER'S MAIDEN NAME: Annie Barnes

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no | (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Mrs. Mary E. Lare, Mt. Airy, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

420 1 **Immediate cause.** (a) Coronary artery disease

94a **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☑

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☑ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE: James T. Shand (Degree or title) Deputy Medical Examiner ADDRESS Westminster Md DATE SIGNED Nov 3-49

23. BURIAL, CREMATION REMOVAL (Specify) BURIAL | DATE THEREOF 11-6-1949 | NAME OF CEMETERY ~~OR CREMATORY~~ Mt. Olivet | LOCATION (City, town, or county) (State) Frederick, Md.

DATE REC'D BY LOCAL REG. Nov. 5-1949 | REGISTRAR'S SIGNATURE Thos D Shuyder

24. FUNERAL DIRECTOR C. M. Waltz, ADDRESS Winfield, Md.

VS. A15A

RECEIVED
NOV 8 1949
BUREAU Y. S.

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS. A15

T

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10631

CERTIFICATE OF DEATH

Reg. Dist. No. 77

1. PLACE OF DEATH: COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hampstead (Rural) LENGTH OF STAY (in this place) 25 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS —

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hampstead - Rural
STREET ADDRESS (If rural, give location) —

3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) MARY - W - LEE

4. DATE OF DEATH (Month) (Day) (Year) Nov 15 1949

5. SEX F

6. COLOR OR RACE W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) W

8. DATE OF BIRTH Apr 24-1868

9. AGE last birthday 81 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None

10b. KIND OF BUSINESS OR INDUSTRY —

11. BIRTHPLACE (State or foreign country) Penna

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Samuel W. Radebaugh

14. MOTHER'S MAIDEN NAME Catherine Pennell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No

16. SOCIAL SECURITY NO. —

17. INFORMANT Miss Mary LEE

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Myocarditis - Chronic, decompensating	2 yrs
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Hypertension	3 yrs
	(c) Arteriosclerosis	

443
93d

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Chronic Cholycystitis

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURRED While at Work ☐ Not While At work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-1-, 1935, to 11-15-, 1949, that I last saw the deceased alive on 11-15-, 1949, and that death occurred at 64 m., from the causes and on the date stated above.

SIGNATURE James G. Saffell (Degree or title) M.D. ADDRESS Reisterstown Md DATE SIGNED 11-16-49

23. BURIAL, CREMATION REMOVAL (Specify) Burial DATE THEREOF Nov 18/49 NAME OF CEMETERY OR CREMATORY Bedford LOCATION (City, town, or county) Bedford (State) Pa

DATE REC'D BY LOCAL REG. Nov. 16, 1949 REGISTRAR'S SIGNATURE John S. Hughes

24. FUNERAL DIRECTOR Edw C Gipton, Hampstead, Md ADDRESS

10632

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH: COUNTY Carroll MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Henryton — LENGTH OF STAY (in this place) 1yr.1mo. 27days	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore 1,
HOSPITAL OR INSTITUTION OR STREET ADDRESS Henryton State Hospital	STREET ADDRESS (If rural, give location) 124 W. Biddle St.,

3. NAME OF DECEASED (Type or Print)	(First) THOMAS	(Middle) MATTHEW	(Last) LILLY	4. DATE OF DEATH	(Month) Nov. (Day) 23 (Year) 1949
5. SEX Male	6. COLOR OR RACE Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH Dec.7,1916	9. AGE last birthday 32 yrs.	If under 1 year Months. Days / If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Red Springs, N.Carolina	12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME James W. Lilly		14. MOTHER'S MAIDEN NAME Jessie Mc Claurin			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Unknown (If year, give war or dates of service)	16. SOCIAL SECURITY No. 214-16-7678	17. INFORMANT AND ADDRESS Deceased			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Pulmonary Tuberculosis	Feb., 1948
002 Antecedent cause(s)		
13b Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept. 27, 1948, to Nov. 23, 1949, that I last saw the deceased alive on Nov., 23, 1949, and that death occurred at 4:15 A. m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Herbert Hoffman, M.D.		Henryton, Md.	11/23/49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	11-28-49	Mt Zion	Red Springs, N.C.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
11/23/49	Albert Swanhham	C. H. Weer	Sykesville, Md.

Deputy Local

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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NOV 28 1949
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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10633

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH: COUNTY Carroll MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Henryton — LENGTH OF STAY (in this place) 2mo. 23 days	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore 1
HOSPITAL OR INSTITUTION OR STREET ADDRESS Henryton State Hospital	STREET ADDRESS (If rural, give location) 1122 Wilmer Court

3. NAME OF DECEASED (Type or Print)	(First) ROBERT	(Middle) BENJAMIN	(Last) LIPSCOMB	4. DATE OF DEATH	(Month) Nov.	(Day) 25,	(Year) 1949
5. SEX Male	6. COLOR OR RACE Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Divorced	8. DATE OF BIRTH Aug. 25, 1906	9. AGE last birthday 43 yrs.	If under 1 year Months.	Days	If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber	10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Croom, Virginia		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME Jacob Lipscomb			14. MOTHER'S MAIDEN NAME Lora Lee				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)		16. SOCIAL SECURITY NO. 212-10-7642	17. INFORMANT AND ADDRESS Deceased				

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Pulmonary Tuberculosis — June, 1949

002 Antecedent cause(s)

13b Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept. 1, 1949, to Nov. 25, 1949, that I last saw the deceased alive on Nov. 25, 1949, and that death occurred at 5:4 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
Herbert Hoffman, M.D.	Henryton, Maryland.	11/25/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE Nov 26, 1949	NAME OF CEMETERY OR CREMATORY Mt Auburn	LOCATION (City, town, or county) (State) Baltimore City
DATE REC'D BY LOCAL REG. 11/25/49	REGISTRAR'S SIGNATURE Albert Swanbham	24. FUNERAL DIRECTOR Geo. G. Kelson	ADDRESS 1303 Presstman St

Deputy Local

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
NOV 28 1949
BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

10634

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH: COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westminster | LENGTH OF STAY (in this place) 29 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS 60 Liberty St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westminster
STREET ADDRESS (If rural, give location) 60 Liberty

3. NAME OF DECEASED (Type or Print): (First) Sarah (Middle) Irene (Last) Little

4. DATE OF DEATH: (Month) Nov. (Day) 29 (Year) 1949

5. SEX: F | 6. COLOR OR RACE: W | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single | 8. DATE OF BIRTH: Nov. 4 1890 | 9. AGE last birthday: 59 yrs. | If under 1 year: Months / Days | If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Telephone Operator Ret. | 10b. KIND OF BUSINESS OR INDUSTRY: C & P Tel. Co. | 11. BIRTHPLACE (State or foreign country): Westminster Md | 12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: George G. Little | 14. MOTHER'S MAIDEN NAME: Elizabith Ann Houck

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service): no | 16. SOCIAL SECURITY NO.: 212-10-0038 | 17. INFORMANT, AND ADDRESS: Baynard Little 60 Liberty St. Westminster, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Carcinoma of Sigmoid. — Interval Between Onset and Death: 2 years.

153 / 46e

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) ____ (c) ____

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: Nov. 1947. | 19b. MAJOR FINDINGS OF OPERATION: Annular Carcinoma of Sigmoid Flexure | 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov. 4th, 1947, to Nov. 28th, 1949, that I last saw the deceased alive on Nov. 28th, 1949, and that death occurred at 6 A. m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Lucien Bon | ADDRESS: Westminster. Md. | DATE SIGNED: 11/28/49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE: Dec. 1-1949 | NAME OF CEMETERY OR CREMATORY: Bridge Cemetery | LOCATION (City, town, or county) (State): Westminster, Md.

DATE REC'D BY LOCAL REG. 11/29/49 | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR: H. Bankard Son | ADDRESS: Westminster, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
NOV 30 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10635

CERTIFICATE OF DEATH

Reg. Dist. No. 76

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY Carroll; MARYLAND
   CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Finksburg
   LENGTH OF STAY (In this place): 7 Mos
   HOSPITAL OR INSTITUTION OR STREET ADDRESS: Hale Nursing Home

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Baltimore
   CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Glen Morris
   STREET ADDRESS (If rural give location): Hanover Road

3. NAME OF DECEASED (Type or Print): (First) Bertha (Middle) Blanche (Last) Lockman

4. DATE OF DEATH: (Month) Nov (Day) 20 (Year) 1949

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: 4-20-1866

9. AGE last birthday: 83 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: -

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Rev A H Harrison Burke

14. MOTHER'S MAIDEN NAME: Margaret Light

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Bertha M DeVese

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Angina Pectoris — Interval Between Onset and Death: 3 yrs.

420.2 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

946 (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. arteriosclerosis — 5 yrs

19a. DATE OF OPERATION: none. 19b. MAJOR FINDINGS OF OPERATION: none

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): Est. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: none (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour): none. m. INJURY OCCURRED While at Work ☐ Not While At work ☐ HOW DID INJURY OCCUR? none

22. I hereby certify that I attended the deceased from Jan. 19, 1944, to Nov 20, 1949, that I last saw the deceased alive on 11-6, 1949, and that death occurred at 12:30 P m., from the causes and on the date stated above.

SIGNATURE: D. D. Eagles (Degree or title) M.D. ADDRESS: Reisterstown, Md DATE SIGNED: Nov 21'49

23. BURIAL, CREMATION / REMOVAL (Specify): Burial DATE THEREOF: Nov 22 1949 NAME OF CEMETERY OR CREMATORY: St Paul's Cemetery LOCATION (City, town, or county) (State): Arcadia Md

DATE REC'D BY LOCAL REG. 11/21/49 REGISTRAR'S SIGNATURE: J. Woodward

24. FUNERAL DIRECTOR ADDRESS: Wm Berryman & Sons Reisterstown Md

RECEIVED
NOV 23 1949

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

10636

Reg. Dist. No. 81

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Bark Hill
LENGTH OF STAY (In this place): Opens
HOSPITAL OR INSTITUTION OR STREET ADDRESS:

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Union Bridge Rural
STREET ADDRESS (If rural, give location): Bark Hill

3. NAME OF DECEASED (Type or Print): (First) Martha (Middle) M (Last) Matthews

4. DATE OF DEATH: (Month) Nov (Day) 1 (Year) 1949

5. SEX: female

6. COLOR OR RACE: colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widowed

8. DATE OF BIRTH: March 9-1882

9. AGE last birthday: 67 yrs. — If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Carroll County, Md

12. CITIZEN OF WHAT COUNTRY?: US

13. FATHER'S NAME: John H Thompson

14. MOTHER'S MAIDEN NAME: Elizabeth Wilson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service):

16. SOCIAL SECURITY NO.: none

17. INFORMANT AND ADDRESS: Gertrude Brooke, Union Bridge, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

156.1 **Immediate cause** (a) Carcinoma Liver

Antecedent cause(s)

146 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | **19b. MAJOR FINDINGS OF OPERATION** | **20. AUTOPSY?** Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct. 1, 1948, to Nov. 1, 1949, that I last saw the deceased alive on Oct. 29, 1949, and that death occurred at 10 00 P m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
M. E. Robertson	M.D.	New Windsor, Md.	11/3/49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Nov 4-1949	Mt Joy Cemetery	Uniontown, Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
11/3.1949	[illegible]	D D Hafer & Sons	Union Bridge - New Windsor, Md

RECEIVED
MAY 5 1949
BUREAU U. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

10637

Reg. Dist. No. 74

1. PLACE OF DEATH: COUNTY Carroll — STATE MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Sykesville — LENGTH OF STAY (In this place) 8 Mo. 2 Days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Baltimore City
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore, Md.
STREET ADDRESS (If rural give location) 1904 E. Lanvale St.

3. NAME OF DECEASED (Type or Print): (First) Constantine (Middle) Vincent (Last) McGuire

4. DATE OF DEATH: (Month) 11 (Day) 19 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Seperated

8. DATE OF BIRTH: 7-19-1897

9. AGE last birthday: 52 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Ireland

12. CITIZEN OF WHAT COUNTRY? ?

13. FATHER'S NAME: Joseph McGuire

14. MOTHER'S MAIDEN NAME: Josephine Conne

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Sister-Mrs Josephine Kinsella

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

962.9 / 77d

Immediate cause (a) Epileptic Convulsion — 2½ Hrs.

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) A Skull Injury 1919

(c) Chronic Alcoholism And Epilepsy — 10 Yrs.

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Psychosis, Deli rium Tremens.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3-17, 1949 to 11-19, 1949, that I last saw the deceased alive on 11-18, 1949, and that death occurred at 7 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Springfield State Hospital 11-19-49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF 11-22-49 — NAME OF CEMETERY OR CREMATORY: Holy Redeemer — LOCATION (City, town, or county) (State): Balto. Md.

DATE REC'D BY LOCAL REG. Nov. 20, 1949 — REGISTRAR'S SIGNATURE: Henry Keer

24. FUNERAL DIRECTOR: William Cook, Inc. — ADDRESS: 1217 E. Pratt St. Balto. Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

10638

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH · COUNTY: Carroll MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Maryland COUNTY:
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Henryton — LENGTH OF STAY (in this place): 2 mon. 3 days	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore-23
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Henryton State Hospital	STREET ADDRESS (If rural, give location): 1321 Edmondson Ave.

3. NAME OF DECEASED (Type or Print)	(First) William	(Middle) Edward	(Last) Miller	4. DATE OF DEATH	(Month) Nov. (Day) 12, (Year) 1949
5. SEX: Male	6. COLOR OR RACE: Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Sep.	8. DATE OF BIRTH: 8-21-11	9. AGE last birthday: 38 yrs.	If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Musican	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): Baltimore, Maryland	12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME: William E. Miller	14. MOTHER'S MAIDEN NAME: Katie Boston				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If year, give war or dates of service)	16. SOCIAL SECURITY No.: 201-25-0407	17. INFORMANT AND ADDRESS: Mrs. Katie Miller (mother)			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause	(a) Pulmonary Tuberculosis	7/11/49
Antecedent cause(s)		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept. 9, 1949 to Nov. 12, 1949, that I last saw the deceased alive on Nov. 12, 1949, and that death occurred at 5: A. m., from the causes and on the date stated above.

SIGNATURE: Reuben Hoffman, M.D. (Degree or title) — ADDRESS: Henryton, Maryland — DATE SIGNED: 11-12-49

23. BURIAL, CREMATION REMOVAL (Specify): Burial	DATE: 11-16-49	NAME OF CEMETERY OR CREMATORY: Arbutus, Cem.	LOCATION (City, town, or county): Arbutus (State): Md.
DATE REC'D BY LOCAL REG.: 11-12-49	REGISTRAR'S SIGNATURE: Albert Swanson Hans	24. FUNERAL DIRECTOR: Mrs. Katie P. Williams - N. Schnaider St	ADDRESS: 322

Deputy Local

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

FEB 16 1949
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

10639

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

M

1

VS: A15

1. PLACE OF DEATH: COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Sykesville
LENGTH OF STAY (In this place) 5 yrs. 2 mos. 11 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN 9325 Jones Mill Road
STREET ADDRESS (If rural give location) Chevy Chase 15, Maryland

3. NAME OF DECEASED (Type or Print): (First) Annie (Middle) M. (Last) Morningstar
4. DATE OF DEATH: (Month) 11 (Day) 17 (Year) 1949
5. SEX: female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married
8. DATE OF BIRTH: 11-9-77
9. AGE last birthday: 72 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY: Housework
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: John Geisler
14. MOTHER'S MAIDEN NAME: Susan Nicholas
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No. (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

002 Immediate cause (a) Pulmonary Tuberculosis — 18 yrs.

136 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Psychosis with Cerebral arteriosclerosis — 5 yrs.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY
(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 6, 1944, to Nov. 17, 1949, that I last saw the deceased alive on Nov. 17, 1949, and that death occurred at 1:20 A. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Robert W. Taylor M.D.
ADDRESS Springfield State Hospital Sykesville, Maryland
DATE SIGNED Nov. 17, 1949

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF Nov. 19, 1949
NAME OF CEMETERY OR CREMATORY Bamesville
LOCATION (City, town, or county) (State) Montgomery Co. Md.

DATE REC'D BY LOCAL REG. Nov 17, 1949
REGISTRAR'S SIGNATURE C. Harry Keen
24. FUNERAL DIRECTOR Wm. P. Hilton
ADDRESS Bamesville Md.

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BUREAU V. S.

10640

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH: COUNTY CARROLL MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINSTER
LENGTH OF STAY (in this place) 17 YRS.
HOSPITAL OR INSTITUTION OR STREET ADDRESS METHODIST CHURCH HOME

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND COUNTY CARROLL
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINSTER
STREET ADDRESS (If rural give location) COR. MAIN + CHURCH STS.

3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) MARY E. PORTER

4. DATE OF DEATH (Month) (Day) (Year) NOV. 26 1949

5. SEX FEMALE
6. COLOR OR RACE WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) WIDOW
8. DATE OF BIRTH JUNE 4, 1861
9. AGE last birthday 88 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE
10b. KIND OF BUSINESS OR INDUSTRY NONE
11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME HENRY BARWICK
14. MOTHER'S MAIDEN NAME MARY WILLOUGHBY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service) —
16. SOCIAL SECURITY NO. NONE
17. INFORMANT CHURCH HOME RECORD

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cardiac Dilatation — INTERVAL BETWEEN ONSET AND DEATH 1 wk

Antecedent cause(s) 422.2 93d (b) Chronic Myocarditis — 5 Years

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from —, 1940 to 11/26, 1949, that I last saw the deceased alive on 11/24, 1949, and that death occurred at 6:30a m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Lenrick Woodward M.D. ADDRESS Westminster DATE SIGNED 11/26/49

23. BURIAL, CREMATION REMOVAL (Specify) BURIAL
DATE NOV. 28, 1949
NAME OF CEMETERY OR CREMATORY WESTMINSTER CEM.
LOCATION (City, town, or county) WESTMINSTER (State) MD.

DATE REC'D BY LOCAL REG. 11/26/49
REGISTRAR'S SIGNATURE L. Woodward
24. FUNERAL DIRECTOR J. FRANCIS REESE ADDRESS WESTMINSTER, MD.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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NOV 8
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10641

CERTIFICATE OF DEATH

Reg. Dist. No. 75

1. PLACE OF DEATH · COUNTY Carroll. MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Alesia — LENGTH OF STAY (in this place) 25 yrs	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Alesia
HOSPITAL OR INSTITUTION OR STREET ADDRESS —	STREET ADDRESS (If rural give location) —

3. NAME OF DECEASED (Type or Print) (First) Andrew. (Middle) (Last) Pringle

4. DATE OF DEATH (Month) Nov. (Day) 1 (Year) 1949

5. SEX Male — 6. COLOR OR RACE White. — 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married. — 8. DATE OF BIRTH Apr. 1 1870 — 9. AGE last birthday 79 yrs. — If under 1 year Months Days — If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming. — 10b. KIND OF BUSINESS OR INDUSTRY Agriculture — 11. BIRTHPLACE (State or foreign country) Manassas Va. — 12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME Thomas Pringle. — 14. MOTHER'S MAIDEN NAME Rebecca Gerlick.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) — 16. SOCIAL SECURITY NO. — 17. INFORMANT Mrs. Andrew Pringle

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

422.1 Immediate cause (a) Chronic Myocarditis ?

52b Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Arteriosclerotic Cardio Vascular disease ?

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Carcinoma Bladder

19a. DATE OF OPERATION — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5-1, 1946, to Nov 1, 1949, that I last saw the deceased alive on Oct 30, 1949, and that death occurred at 3 A m., from the causes and on the date stated above.

SIGNATURE Joseph E Bush (Degree or title) MD — ADDRESS Hampstead Md — DATE SIGNED 11-1-49

23. BURIAL, CREMATION REMOVAL (Specify) Burial — DATE THEREOF 11-3-49 — NAME OF CEMETERY OR CREMATORY Sudley cemetery — LOCATION (City, town, or county) Prince William Co. (State) Va.

DATE REC'D BY LOCAL REG. Nov. 2/49 — REGISTRAR'S SIGNATURE Mrs. H. R. S. Denner — 24. FUNERAL DIRECTOR Jacob Winters Sons — ADDRESS Manchester Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
NOV 8 1949
BUREAU T. S.

MARYLAND STATE DEPARTMENT OF HEALTH

10642

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY: Carroll — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Sykesville — LENGTH OF STAY (in this place): since 4/22/46
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland — COUNTY: ---
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore City
STREET ADDRESS (If rural give location): 3931 Greenmount Avenue

3. NAME OF DECEASED (Type or Print): (First) Henry (Middle) --- (Last) RASCH

4. DATE OF DEATH: (Month) November (Day) 21 (Year) 19 49

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married

8. DATE OF BIRTH: April 7, 1890

9. AGE last birthday: 59 yrs. — If under 1 year: Months — Days — If under 24 hrs.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cook, salesman, carpenter

10b. KIND OF BUSINESS OR INDUSTRY: ---

11. BIRTHPLACE (State or foreign country): Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY?: United States

13. FATHER'S NAME: Henry Rasch, Sr.

14. MOTHER'S MAIDEN NAME: Elizabeth Koch

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): unknown — (If yes, give war or dates of service): unknown

16. SOCIAL SECURITY NO.: unknown

17. INFORMANT: Records - Springfield State Hospital

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

334 Immediate cause (a) Arteriosclerosis — more than 3 yrs.

97 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) --- (c) ---

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death: Psychosis with cerebral arteriosclerosis — 3½ yrs.

19a. DATE OF OPERATION: --- — 19b. MAJOR FINDINGS OF OPERATION: --- — 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): --- — PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: --- — (CITY OR TOWN): --- — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour): --- m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?: ---

22. I hereby certify that I attended the deceased from Sept. 1, 1947, to Nov. 21, 1949, that I last saw the deceased alive on Nov. 21, 1949, and that death occurred at 8:05 a.m., from the causes and on the date stated above.

SIGNATURE: Martin Gross, M. D. (Degree or title) — ADDRESS: Sykesville, Maryland — DATE SIGNED: 11/21/49

Martin Gross, M.D.

23. BURIAL, CREMATION, REMOVAL (Specify): burial — DATE THEREOF: 11/25/49 — NAME OF CEMETERY OR CREMATORY: Black Rock Cemetery — LOCATION (City, town, or county) (State): Butler, Maryland

DATE REC'D BY LOCAL REG.: Nov. 21, 1949 — REGISTRAR'S SIGNATURE: C. Harry Weer

24. FUNERAL DIRECTOR: Wm. Cook, Inc., — ADDRESS: 1217 St. Paul Street

VS. A15

RECEIVED
NOV 23 1949

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

10643

Reg. Dist. No. 24

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Henryton | LENGTH OF STAY (in this place) 3 mos. 10 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Henryton State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Dorchester
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Reids Grove
STREET ADDRESS (If rural, give location) R.F.D.#1 Box174 Rhodesdale, P.O.

3. NAME OF DECEASED (Type or Print): (First) WILLIAM (Middle) McKinley (Last) Rideout

4. DATE OF DEATH: (Month) Nov. (Day) 1, (Year) 19 49

5. SEX: MALE

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: 10-25-26

9. AGE last birthday: 23 yrs. | If under 1 year: Months. Days | If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Reids Grove Md.

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Louis Rideout

14. MOTHER'S MAIDEN NAME: Nona Dennis

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO | (If year, give war or dates of service):

16. SOCIAL SECURITY NO.: 218-20-6954

17. INFORMANT: Deceased

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

002 **Immediate cause** (a) Pulmonary Tuberculosis — Interval between onset and death: Dec. 1948

13b **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 22, 19 49 to Nov. 1, 19 49, that I last saw the deceased alive on Nov. 1, 19 49, and that death occurred at 6: A. m., from the causes and on the date stated above.

SIGNATURE Herbert Hoffman, M. D. (Degree or title) ADDRESS Henryton, Maryland DATE SIGNED 11-1-49

23. BURIAL, CREMATION, REMOVAL (Specify) Burial | DATE 11-4-49 | NAME OF CEMETERY OR CREMATORY Reids Grove | LOCATION (City, town, or county) (State) Dorchester Co., Md.

DATE REC'D BY LOCAL REG. 11-1-49 | REGISTRAR'S SIGNATURE Albus A. Trunkhouse, Deputy Local | 24. FUNERAL DIRECTOR J. J. Frampton | ADDRESS Fredericksburg, Md.

RECEIVED
NOV 3 1959
BUREAU OF S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10644

CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY: Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural; Sykesville
LENGTH OF STAY (in this place): 2 mo.s 3 ds
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland — COUNTY:
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore
STREET ADDRESS (If rural, give location): 1416 Dellwood Avenue (11)

3. NAME OF DECEASED (Type or Print): (First) Elizabeth (Middle) McDonald (Last) Rooney

4. DATE OF DEATH: (Month) Nov. (Day) 15 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: 11/20/86

9. AGE last birthday: 62 yrs. — If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mill worker

10b. KIND OF BUSINESS OR INDUSTRY: Cotton

11. BIRTHPLACE (State or foreign country): Baltimore City

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: ———— McDonald

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If year, give war or dates of service):

16. SOCIAL SECURITY No.: none

17. INFORMANT AND ADDRESS: Hospital Records; Sykesville, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Aspiration pneumonia - right lower lobe	2 days
Antecedent cause(s)		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Toxic - exhaustive state	2 weeks
4200 93d	(c) Arteriosclerotic heart disease	Indefinite

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:
(CITY OR TOWN) (COUNTY) (STATE):
TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sep. 12, 1949, to Nov. 15, 1949, that I last saw the deceased alive on Nov. 15, 1949, and that death occurred at 7:20 P.m., from the causes and on the date stated above.

SIGNATURE: Henry C. A. Mead (Degree or title): M. D. ADDRESS: Sprigfield State Hospital, P.O. Md. DATE SIGNED: 11/15/49

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE: 11-18-49 — NAME OF CEMETERY OR CREMATORY: Woodlawn — LOCATION (City, town, or county) (State): Balto. Md.

DATE REC'D BY LOCAL REG.: 11-16-49 — REGISTRAR'S SIGNATURE: C. Harry Weir

24. FUNERAL DIRECTOR: John C. Mitchell & Sons — ADDRESS: 1900 Eutaw Place Balto. Md.

RECEIVED
NOV 17 1949
BUREAU OF S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10645

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH: COUNTY Carroll; MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Henryton; LENGTH OF STAY (in this place) 8 days	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore 2
HOSPITAL OR INSTITUTION OR STREET ADDRESS Henryton State Hospital	STREET ADDRESS (If rural, give location) 1122 Somerset St.,

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
HENRY		SCOFIELD	Nov.	10,	19 49

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months. / Days	If under 24 hrs.: Hours / Min.
MALE	Negro	single	Feb. 22, 1909	40 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer		Greenville, S. Carolina	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
James Scofield	Carrie Gilliam

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
NO	218-01-8175	MRS. MABLE SCOTT (sister)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) Pulmonary Tuberculosis	July, 1949
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)	
(c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from NOV. 2, 19 49 to Nov. 10, 19 49 that I last saw the deceased alive on Nov. 10, 19 49 and that death occurred at 11:45 A.m., from the causes and on the date stated above.

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
Robert Hoffman, M.D.	Henryton, Maryland	11-10-49

23. BURIAL, CREMATION / REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	11-15-49	Mt Calvary Cem	A. A. Co	Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
11-10-49	Albert [illegible] Deputy Local	Rayner Sanders	1412 E. Preston St

RECEIVED
OCT 10 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

10646

Reg. Dist. No. 74

1. PLACE OF DEATH: COUNTY Carroll MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Sykesville

LENGTH OF STAY (In this place) 8 months

HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY P.G.

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Lanham

STREET ADDRESS (If rural give location) 106 Worrell Ave

3. NAME OF DECEASED (Type or Print) (First) Lucy (Middle) H (Last) Shackleford

4. DATE OF DEATH (Month) Nov (Day) 4th (Year) 1949

5. SEX F

6. COLOR OR RACE W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single

8. DATE OF BIRTH Nov-27-1881

9. AGE last birthday 67 yrs. If under 1 year Months 11 Days 8 If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse

10b. KIND OF BUSINESS OR INDUSTRY Nurse

11. BIRTHPLACE (State or foreign country) Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME John Shackleford

14. MOTHER'S MAIDEN NAME Ella Brown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) No

16. SOCIAL SECURITY No. Unk-

17. INFORMANT Mrs Mattie Dodson

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331

Immediate cause (a) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH 10 da

83a

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Genl Arterio Sclerosis — 6 yrs.

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb 24, 1949, to Nov 4, 1949, that I last saw the deceased alive on Nov 4th, 1949, and that death occurred at 11-30 m., from the causes and on the date stated above.

SIGNATURE M J Mastin (Degree or title) M.D. ADDRESS Sykesville Md. DATE SIGNED Nov 4th-49

23. BURIAL, CREMATION REMOVAL (Specify) Burial

DATE THEREOF 11-8-49

NAME OF CEMETERY OR CREMATORY Washington National Park

LOCATION (City, town, or county) (State) Washington, D.C.

DATE REC'D BY LOCAL REG. Nov. 5, 1949

REGISTRAR'S SIGNATURE C. Harry Weer

24. FUNERAL DIRECTOR W. W. Chambers - Riverdale, Md. ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

RECEIVED
AUG 8 1949
BUREAU U. S.

MARYLAND STATE DEPARTMENT OF HEALTH

10647

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Sykesville
LENGTH OF STAY (in this place): 3 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland
COUNTY: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore
STREET ADDRESS (If rural, give location): 710 N. Streeper Street

3. NAME OF DECEASED (Type or Print): (First) Emma Jane (Middle) (Last) S h o o k (Shoop)

4. DATE OF DEATH: (Month) 11 (Day) 12 (Year) 1949

5. SEX: female

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): separated

8. DATE OF BIRTH: 7-12-74

9. AGE last birthday: 75 yrs. If under 1 year: Months —, Days —, If under 24 hrs.: Hours —, Min. —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Baltimore

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Frank Hurtt

14. MOTHER'S MAIDEN NAME: Emma Jane Smith

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): — (If year, give war or dates of service): —

16. SOCIAL SECURITY NO.: —

17. INFORMANT AND ADDRESS: Springfield State Hospital

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

422.2 **Immediate cause** (a) acute myocarditis — Interval between onset and death: a few minut

93d **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b) chronic myocarditis — for about 3 years
(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Psychosis with cerebral arteriosclerosis — 8 years

19a. DATE OF OPERATION: —

19b. MAJOR FINDINGS OF OPERATION: —

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): —

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: —

(CITY OR TOWN): — (COUNTY): — (STATE): —

TIME OF INJURY (Month) (Day) (Year) (Hour): — m.

INJURY OCCURRED While at Work ☐ Not While At work ☐ —

HOW DID INJURY OCCUR?: 1st. —

22. I hereby certify that I attended the deceased from November, 1949, to Nov. 12, 1949, that I last saw the deceased alive on Nov. 12, 1949, and that death occurred at 11 40 p m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Henry Carroll, M.D. — ADDRESS: Springfield State Hospital P.O. — DATE SIGNED: 11/13/49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE: Nov. 15, 1949 — NAME OF CEMETERY OR CREMATORY: Loudon Park — LOCATION (City, town, or county) (State): Baltimore Md.

DATE REC'D BY LOCAL REG.: Nov. 13, 1949 — REGISTRAR'S SIGNATURE: C. Haney Keen

24. FUNERAL DIRECTOR — ADDRESS: John A. Miller, 2334 Jefferson St. Balto. Md.

RECEIVED
NOV 15 1949
BUREAU V. S.

10648

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH: COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Westminster
LENGTH OF STAY (in this place) 2 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS R.D. # 4

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Westminster
STREET ADDRESS (If rural, give location) R.D. # 4

3. NAME OF DECEASED (Type or Print) (First) Elsie (Middle) Maude (Last) Smith

4. DATE OF DEATH (Month) Nov. (Day) 22 (Year) 1949

5. SEX F
6. COLOR OR RACE W
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) widow
8. DATE OF BIRTH Oct. 17-1888
9. AGE last birthday 61 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none
10b. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (State or foreign country) Md.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Alfred Buckingham
14. MOTHER'S MAIDEN NAME Fannie Gingling

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)
16. SOCIAL SECURITY No. None
17. INFORMANT AND ADDRESS Frank Tawney Westminster R.D. 4, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			Interval Between Onset and Death
241	Immediate cause	(a) Myocarditis (acute)	7 days
61	Antecedent cause(s)	(b) Asthma, Diabetes, hypertension	years
	Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov 1, 1949, to Nov 22, 1949, that I last saw the deceased alive on Nov 21, 1949, and that death occurred at 3 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) W. C. Jennette ADDRESS Westminster, Md DATE SIGNED 11-22-49

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE Nov. 24-1949
NAME OF CEMETERY OR CREMATORY Lesters Cemetery
LOCATION (City, town, or county) (State) Westminster 4, Md.

DATE REC'D BY LOCAL REG. 11/23/49
REGISTRAR'S SIGNATURE [signature]
24. FUNERAL DIRECTOR ADDRESS A Bankard & Son Westminster, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

10649

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 8 2

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Ridgeville
LENGTH OF STAY (In this place) Life
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Ridgeville
STREET ADDRESS (If rural, give location) Rural --Mt. Airy (Estimated)

3. NAME OF DECEASED (Type or Print): (First) BENEDICT (Middle) B. (Last) SNYDER
4. DATE OF DEATH: (Month) Nov. (Day) 15th (Year) 1949
5. SEX: MALE
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): widowed
8. DATE OF BIRTH: 5-19-1871
9. AGE last birthday: 78 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: Theodore Snyder
14. MOTHER'S MAIDEN NAME: Sarah Moxley
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Mrs. Susan Renner, Mt. Airy, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Disease of Coronary Arteries	several years
420.1 Antecedent cause(s) Diseases or conditions, If any, giving rise to the above cause stating the underlying cause last 94a	(b) (Body was found beside chicken house	
	(c) when deceased had been working with tools)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY
(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☑ thereon and from the evidence obtained by said ~~Autopsy~~, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
N. Billingsley, M.D. acting Deputy Medical Examiner Westminster, Md. 11-20-49

23. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
DATE THEREOF: 11-21-49
NAME OF CEMETERY OR CREMATORY: Pine Grove
LOCATION (City, town, or county) (State): Mt. Airy, Maryland

DATE REC'D BY LOCAL REGISTRAR: Nov 21/49
REGISTRAR'S SIGNATURE: Wm D Snyder
24. FUNERAL DIRECTOR: C.M. Waltz, ADDRESS: Winfield, Md.

VS. A15A

RECEIVED
NOV 23 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10650

CERTIFICATE OF DEATH

Reg. Dist. No. 77

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

M

I

T

VS. A15

1. PLACE OF DEATH: COUNTY Carroll — STATE MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hampstead — LENGTH OF STAY (in this place) 6 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS —

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hampstead
STREET ADDRESS (If rural give location) —

3. NAME OF DECEASED (Type or Print): (First) LAWRENCE (Middle) G (Last) SNYDER

4. DATE OF DEATH: (Month) Nov (Day) 10 (Year) 1949

5. SEX: M — 6. COLOR OR RACE: W — 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): W. — 8. DATE OF BIRTH: 3-24-1865 — 9. AGE last birthday: 84 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired — 10b. KIND OF BUSINESS OR INDUSTRY: Farmer — 11. BIRTHPLACE (State or foreign country): Maryland — 12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Samuel J Snyder — 14. MOTHER'S MAIDEN NAME: Rebecca Cunnine

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no — 16. SOCIAL SECURITY NO. — 17. INFORMANT: Mrs Norman Murray

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Chronic Myocarditis — ?

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Arteriosclerotic Cardiovascular Disease — ?

(c)

442
131a

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. —

19a. DATE OF OPERATION — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY — (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov. 12, 1946 to Nov 10, 1949, that I last saw the deceased alive on Nov 9, 1949, and that death occurred at 3 A. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Jacob E Bush M.D Hampstead Md 11-10-49

23. BURIAL, CREMATION REMOVAL (Specify) Burial — DATE THEREOF 11-13-49 — NAME OF CEMETERY OR CREMATORY Lyndenburg — LOCATION (City, town, or county) Carroll Co (State) Md

DATE REC'D BY LOCAL REG. Nov. 12, 1949 — REGISTRAR'S SIGNATURE John S. Hughes, Jr. — 24. FUNERAL DIRECTOR Edw Clifton — ADDRESS Hampstead Md

NOV 13 1940
BUREAU P. R.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

10651

Reg. Dist. No. 74

1. PLACE OF DEATH: COUNTY Sykesville MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Harford
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural- Sykesville; LENGTH OF STAY (in this place) 2 yrs. 3 mos. 23 days	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Sharon
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital	STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print)	(First) GEORGE	(Middle) Washington	(Last) SWEETING, JR.	4. DATE OF DEATH	(Month) 11	(Day) 24	(Year) 1949
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH 9/7/87	9. AGE last birthday 62 yrs.	If under 1 year Months	Days	If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	10b. KIND OF BUSINESS OR INDUSTRY Agriculture	11. BIRTHPLACE (State or foreign country) Pennsylvania	12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME Not known	14. MOTHER'S MAIDEN NAME Not known						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) Navy	16. SOCIAL SECURITY NO. Unknown	17. INFORMANT Record, Springfield State Hospital					

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Pulmonary Tuberculosis	2 yrs.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c)	

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30g

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Involutional Depression, plus pulmonary tuberculosis and systemic syphilis ?

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/1, 1947, to 11/24, 1949, that I last saw the deceased alive on 11/24, 1949, and that death occurred at 11:45 A EST m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Henry C. A. Mead	M. D.	Sykesville, Maryland	11/24/49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Nov 27-49	Wm Watters Cem.	Coopertown, Harford Co Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Nov 25, 1949	C. Harry Keer	Charles E. Kurtz	Jarrettsville Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
NOV 28 1949
BUREAU U. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10652

CERTIFICATE OF DEATH

Reg. Dist. No. 76

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY Carroll — STATE MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Westminster — LENGTH OF STAY (In this place) Life
HOSPITAL OR INSTITUTION OR STREET ADDRESS Route 6

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. — COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Westminster
STREET ADDRESS (If rural give location) Route 6

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Joseph	Henry	Ward	Nov.	20	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
M	W	W	March 2 1871	78 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer, retired		Maryland	U.S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
John Ward	Sarah Early

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
no	none	Mr. Charles Ward

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
420.1 Immediate cause	(a) Coronary artery disease	
Antecedent cause(s)		
94a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Arteriosclerosis	
	(c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from ....., 19....., to ....., 19....., that I last saw the deceased alive on ....., 19....., and that death occurred at 3:00 P. m., from the causes and on the date stated above.

SIGNATURE James T. Marsh, Deputy Medical Examiner — (Degree or title) — ADDRESS Westminster Md — DATE SIGNED 11/20/49

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
BURIAL	11-23-1949	Wards Chapel	Baltimore Co., Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
11-23-49	[signature]	C. M. Waltz,	Winfield, Md.